SEX, GENDER AND HEALTH: A CONCEPTUAL NOTE

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I. CONCEPT OF SEX AND GENDER

What makes a female different from a male? Is it different reproductive system? Is it certain hormones which are different in nature and amount in the two sexes? Is it their differential susceptibility and resistance to certain diseases? Or is it something more than that. It is certain that the differences specified above are not sufficient enough for the existent g*ender gap* in the society. Probably, it is something more than that which is related to socio-cultural construct that contribute to a large extent for such a disparity.

Let us first understand how Gender is different from Sex. **"**Sex" refers to the *biological and physiological* characteristics that define men and women. **"**Gender**"** refers to the *socially constructed* roles, behaviors, activities, and attributes that a given society *considers appropriate* for men and women (WHO, 2007). It is abstract in nature: it is not concrete, visible and countable. It is relational in nature: gender does not refer to women or to men, but to the system of relations between them. Some examples of sex characteristics are women menstruate, can become pregnant, have developed breasts and lactate (WHO, 2007); men typically develop heart disease ten years earlier than women, women are around 2.7 times more likely than men to develop an autoimmune disease; male to female infection with HIV is more than twice as efficient as female-to-male infection (GFHR, 2004); girls are more likely to survive the first five years of life than boys (WHO, 2003) et cetera. Some examples of gender characteristics are women are more emotional than men, do less productive work than men, are better carriers of children (WHO, 2007); in most countries, more men commit suicide than women, but women are more likely to attempt it; both community based studies and research on treatment seekers indicate that women are two to three times more likely than men to be affected by common mental disorders such as depression or anxiety; men are more likely than women to die of injuries, but women are more likely to die of injuries sustained at home; the larger differences between male and female smoking rates are beginning to narrow as young women are taking up the habit more frequently than young men (GFHR, 2004).

Differences between Sex and Gender

Sex	Gender
Biological	Socio-cultural construct(learned)
Nature- made	Society- made
Constant	Variable (changes over time)
Individual	Systemic (differs with society)
Non- Hierarchical	Hierarchical (binds the person to certain roles and responsibilities)
Cannot be changed	Difficult, not Impossible to change

II. CONCEPT OF HEALTH

Health is a multifaceted concept and thus it defies any precise definition. The narrow definition of health posits it as the absence of disease. The broad definition of health, however, does not rest merely on the absence of disease but the fulfillment of a whole range of personal, physiological, mental, social and even moral goals. World Health Organization's (WHO) constitution defines health as "*a state of complete physical, mental and social well being and not merely the absence of disease or infirmity*" (WHO, 1992). Although, this definition is a fine and inspiring concept and its pursuit guarantees health professionals unlimited opportunities for carry out work in future, it may not be of much practical

relevance (Doll, 1992) and also it seems to work against its effective functioning (Saracci, 1997). Such a definition is too wide and not amenable for any meaningful economic analysis or for any resource allocation.

Necessarily, health has to be defined from a practical point of view and, therefore, it has been defined according to life expectancy, infant mortality, and crude death rate, etc (Reddy, 1992). In fact, it is studied as a function of medical care, income, education, age, sex, race, marital status, environmental pollution, and also certain personal behaviour like smoking habits, exercise, and the like. It is also used as an independent variable to explain labour force participation rates particularly at old age. Not only do retired persons frequently cite poor health as the reason for retirement, but also current workers, who report health limitations, are more likely to withdraw from work in future. Health status is often used to explain wages, productivity, school performance, fertility and the demand for medical care. The results are quite sensitive to the particular measures of health that are used but the direction of the effect generally confirms *a priori* preconditions (Fuchs, 1987).

Problems with the WHO Definition

The WHO definition of health is subjected to serious problems at the conceptual level that impair its guiding role in the wake of the conflict between health needs and resources, both nationally and internationally. In fact, a state of complete physical, mental and social well-being corresponds more closely to happiness than to health. The latter two terms designate distinct life experiences. Sigmund Freud experienced the same clearly after stopping smoking on health reasons. He confessed, "I learned that health was to be had at a certain cost … Thus, I am now better than I was, but not happier" (Saracci, 1997).

Not only health and happiness are distinct but also their relationship is neither fixed nor constant. Having suffered from a serious disease is likely to make one less happy, but not having the same does not necessarily amount to happiness. Common existential problems – involving emotions, passions, personal values, and questions on the meaning of life – can make one less happy or even overtly uncomfortable, but they may not be leading to health problems.

The distinction between health and happiness is relevant in terms of rights, in particular 'positive rights or entitlements', that may seek societal actions to ensure that rights materialize completely and effectively. Whereas it can be argued that health is a positive and universal right, at the same length, it may be difficult to construct an argument that happiness (though not its material and social preconditions) is a positive right as happiness cannot be delivered or imposed on a person by any societal action. Happiness is strictly subjective both as an achievement and as an appreciation (Saracci, 1997).

Consequences of the definition

Failing to distinguish health from happiness has four major consequences (Saracci, 1997).

Firstly, any disturbance to happiness may come to be seen as a health problem. This may make the purpose self-defeating as one brings in subjectivity, while the other is seen from certain objective criteria.

Secondly, because the quest for happiness is essentially boundless, the quest for health also becomes boundless. This legitimizes an unlimited demand for health services. Of course, some people may legitimately decide that they want to pursue happiness as well as health by medical means, as other people may do through music, religion, or love. For example, some people may wish to have their features surgically redesigned to suit some aesthetic ideals. But this preference represents a personal way to happiness rather than a universal right to health.

Thirdly, annexing happiness to health as a universal positive right introduces an underlying prescriptive view of happiness in society. This undervalues personal autonomy and could be established only in totalitarian regimes.

Finally, and more significantly, trying to guarantee the unattainable -happiness for every citizen - may inevitably subtract resources and jeopardize the chances of guaranteeing the attainable - justice and equity in health. The necessary and formidable task of reducing inequalities and achieving equity in health, an emerging issue in the reformulation of the WHO's programmes of action, becomes meaningless if it is not even clear what needs to be equitably distributed.

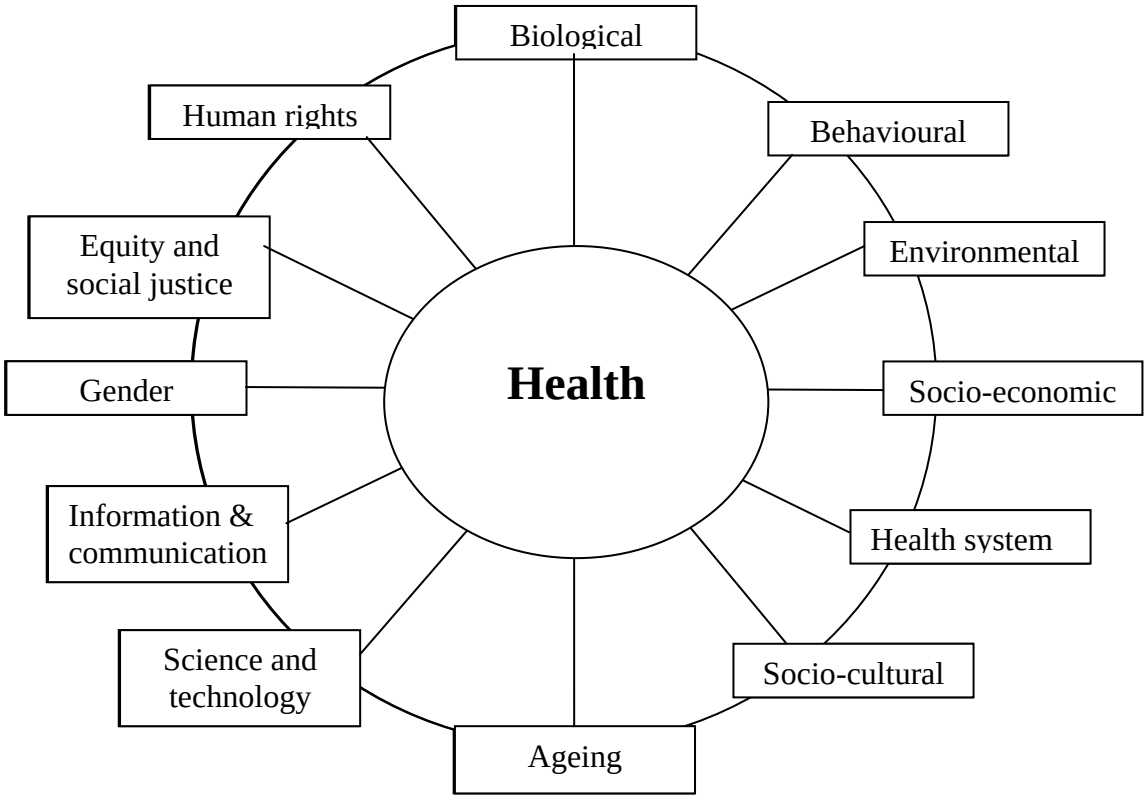
Towards a solution

With a view to remove the fundamental ambiguity that surrounds happiness and health, health may be construed as a condition of well being free of disease or infirmity and basic human rights. This description does not necessarily contradict the definition of health as per the WHO's constitution, rather it provides an intermediate concept linking the WHO's ideas to the health and disease as measurable by appropriate indicators like mortality, morbidity, and quality of life. By removing the ambiguity between health and happiness and emphasizing health as a basic human right, it provides a reference criterion against which one can gauge how far health programmes incorporate and meet the requirements of health equity (Saracci, 1997).

III. SEX AND GENDER AS DETERMINANTS OF HEALTH

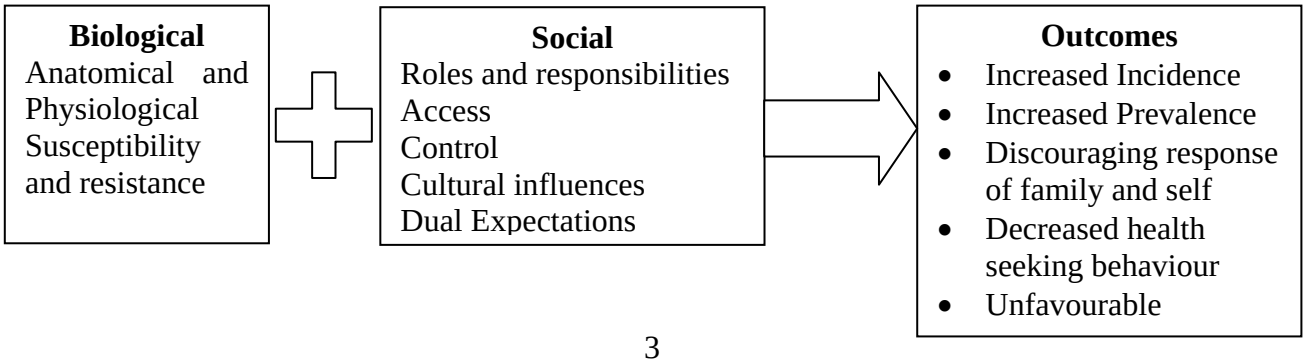
Health is multifactoral. There is a complex interaction between these factors and Health or Disease is a result of these interactions. Health is largely determined by biological determinants, behavioural factors (Health seeking behaviour), environmental factors, socio-economic determinants (Education, Income, Nutrition, Control over one's circumstances, et cetera), health system (Availability of services, Access to these services), socio-cultural factors, ageing of population, science and technology, information and communication, equity and social justice, and human rights (Figure 1).

Figure 1: Determinants of Health



Source: Park (2002)

Figure 2: Biological vulnerability complicated with Gender factors



Gender as a system in society

- Are Men strong and Women weak?
- Are Men rational and Women emotional?

OR

Are they **certain beliefs** in society about men and women?

- It is these beliefs that mostly govern the **behaviour** of men and women in society (e.g. 'men can express themselves, men can be articulate', whereas 'women must not express themselves or be articulate' or 'women should not sit like this or laugh like that' or 'this is what women should do and that job is meant for men only')

- **Different gender roles** for men and women e.g. Men must be breadwinners, women must be carers, nurturers.

Sexual division of labour

For Men	For Women
• Productive- earning member • Community Leadership-Sarpanch	• Reproductive-caring, nurturing • Informal leadership- Dais, Wise women

Therefore, different activities and tasks for men and women

- Women's tasks undervalued and invisible e.g. cooking, cleaning.
- Women's work fragmented.
- Public domain for men, private for women

- **Differential access to and control over resources** like Money (therefore, poverty among women), Land, Technology, Knowledge (Education and important health information), Self-esteem

Differential decision making and power which influences:

- Social beliefs existent in society
- Gender norms for behaviour
- Access to and control over resources
- Sexual division of Labour

Therefore, this becomes a continuous cycle. The result of it is the **sub-ordinate status** (women eat in the last, have less formal education, stay home and female foeticide, a horrifying reality) of women in society which deeply influences their health status

Source: IIHMR (2004)

Biological determinants

Most obviously, women as a group tend to have longer life expectancy than men in the same socio-economic circumstances. Yet despite, their greater longevity, women in most communities report more illness and distress than men**.** One may say, that the reason behind is biological and, therefore, related to Sex and not Gender, but, we must understand that biological vulnerability when complicated with unequal gender related determinants results in much increased morbidity and unfavourable outcomes (Figure 2).

Moreover, women's capacity to conceive and bear children predisposes them to heightened susceptibility and higher risk of having disease especially in a country with a high total fertility rate (TFR) and high maternal mortality ratio (MMR). The tragedy is that these women die not from any disease but during the normal, life-generating process of procreation. Total fertility rate and maternal mortality rate are in turn largely determined by gender factors like son preference, decreased access to health care for women, et cetera.

IV. SEX, GENDER AND HEALTH – NEED MORE ATTENTION

Little systematic research has been done on the social causes of ill-health (Östlin, Sen and George, 2004). Health researchers have overwhelmingly focused on biomedical research at the level of individuals. Investigations into the health of groups and the determinants of health inequities that lie outside the control of the individual have received a much smaller share of research resources. Ignoring factors such as socioeconomic class, race and gender leads to biases in both the content and process of research. Östlin, Sen and George (2004) use two such factors — poverty and gender — to illustrate how this occurs. There is a systematic imbalance in medical journals: research into diseases that predominate in the poorest regions of the world is less likely to be published. In addition, the slow recognition of women's health problems, misdirected and partial approaches to understanding women's and men's health, and the dearth of information on how gender interacts with other social determinants continue to limit the content of health research. In the research community these imbalances in content are linked to biases against researchers from poorer regions and women. Researchers from high-income countries benefit from better funding and infrastructure. Their publications dominate journals and citations, and these researchers also dominate advisory boards. The way to move forward is to correct biases against poverty and gender in research content and processes and provide increased funding and better career incentives to support equity-linked research. Journals need to address equity concerns in their published content and in the publishing process. Efforts to broaden access to research information need to be well resourced, publicized and expanded.

The Global Forum for Health Research believes that a systematic approach to gender issues must be a central part of its strategy for helping correct the 10/90 gap. It is estimated that around 70 per cent of the world’s poor are women. The health of these women is often adversely affected not only by their poverty but also by the gender inequalities that continue to divide many of the world’s poorest countries. In response, the Global Forum is committed to achieving greater gender sensitivity in all its work (Doyal, 2002).

Ensuring greater gender sensitivity in health related research does not mean that this is concerned only with women. Men’s health too may be affected in fundamental ways by both their sex and their gender and this is reflected in the analysis which follows. It is also important to emphasize those differences in the health problems of women and men are not only related to their reproductive biology or its social implications. Though these are important, it is also clear that more general health problems may be experienced very differently by women and men and may have different implications for their lives.

Gender issues in health research should address systematically and adequately by researchers, policy makers, government and organizations concerned with the promotion of development and the enhancement of human well-being. This is because, firstly, gender equality is a core development issue - a development objective in its own right and it strengthens countries' abilities to grow, to reduce poverty, and to govern effectively (King, and Mason, 2001). Secondly, equity requires that both women and men should have the same opportunity to be active citizens, participating in the development process and having equal access to its benefits. Unless this is achieved, individuals will not be able to realize their potential for health and well-being (GFHR, 2004).

Sex and gender are major determinants of health in both women and men. They are closely linked with other variables such as age, race and socioeconomic status in shaping biological vulnerability, exposure to health risks, experiences of disease and disability, and access to medical care

and public health services. Researchers who ignore these differences run the risk of doing bad science. Failures to incorporate sex and gender in research designs can result in failures of both effectiveness and efficiency. It is therefore essential that all those involved in the commissioning and funding of research take issues of sex and gender seriously. Whether they are private companies, government bodies, research councils or charities, appropriate recognition of gender issues should be one of the criteria used for evaluating both the relevance and the scientific quality of proposals. Researchers themselves need to be aware of gender concerns at all stages of their work from the initial design to the dissemination process. And policy-makers need to look very carefully at the sex and gender implications of research findings before deploying them in the development of services (GFHR, 2004).

V. CONCLUSIONS

Social / Gender factors often play a major part in ill-health of women, with gender discrimination in nutrition, education, health care and social support. Gender factors influence the extent to which women are able to have control over their own circumstances affecting their health and the quality of life. These factors are enough to first determine, then mould and finally fluctuate and raise discrepancy in the routine lives of the women. This derision lies in every strata of the society affecting invariably the position of the women.

For women to have a satisfactory health status, which is their basic human right, gender differences have to be tackled with a multi-pronged strategy, manifesting in different sectors and at different levels. The aim of mainstreaming gender in this way is to move towards a position of equality between women and men. It is still important that women's practical needs as well as the strategic needs are given their due regards. Making it easier for a woman to get a job, for instance, may simply increase her overall burden of work if there is no associated change in who does the domestic labour. Thus policies designed to meet women's practical needs must also take their strategic interests into account if they are to be of lasting benefit. And for this to happen, women themselves and men need to be actively involved in their development and implementation.

Health has to be a necessary input to, and goal of, development. It is necessary that women should have sound mental and body in order to participate fully in development process as workers, mothers, family and community members.

Gender norms and values give rise to *gender inequalities* - that is, differences between men and women, who systematically empower one group to the detriment of the other. Both gender differences and gender inequalities can give rise to inequities between men and women in the status of health and access to health care.

Furthermore, given women's subordinate status and the absence of conscious efforts directed solely at meeting their particular needs, women remain on the sidelines in the development planning and are less likely to actualize the benefits envisaged. The participation still remains unsettled and the conceived of benefits and the talks of welfare are far away (IIHMR, 2004).

The good news is that gender norms and values are not fixed. They evolve over time, vary substantially from place to place, and are subject to change. Thus, the poor health consequences resulting from gender differences and gender inequalities are not fixed, either. They can be changed for better.

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